

MEDICAL BOARD OF CALIFORNIA

Licensing Program



Certificate of Individual Clinical Clerkship Training

This form is required of international medical school graduates who completed any clinical training outside of the primary teaching hospital of their medical school. A separate form is to be used for each clinical clerkship.

PROGRAM DIRECTOR OR CLINICAL INSTRUCTOR TO COMPLETE CLERKSHIP INFORMATION Facility Name PROGRAM DIRECTOR OR CLINICAL INSTRUCTOR TO COMPLETE CLERKSHIP INFORMATION Facility Name	Type or Print Legibly	APPLICANT INFORM	IATION			
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CGME 10-digit program # (http://www.acgme.org/adspublic): OFFICIAL CERTIFICATION certify that I am the program director or clinical instructor and that the applicant named above satisfactorily completed the above named clinical clerkship and I hereby declare under penalty of perjury under the laws of the State of California that the above statements are true and correct. PRINT NAME OF PROGRAM DIRECTOR OR CLINICAL INSTRUCTOR Email Address SIGNATURE OF PROGRAM DIRECTOR OR CLINICAL INSTRUCTOR (Signature Stamp Is Not Acceptable) ITENTION: THE PERSON WHO SIGNS THIS FORM MAY NOT BE RELATED TO THE APPLICANT BY BLOOD, MARRIAGE, OR ADOPTION. Only hee Program Director or clinical instructor may sign this form. If that signature authority is being delegated to another person, evidence of that delegation usus to attached to this form (may be a photocopy). Such delegation must be on official letterhead and must least 12 months. NOTE: If a hospital seal is not available, the program director or clinical instructor shall also sign in the section below in the presence of a notary public. Signature of Program Director or Clinical Instructor: County of	Name of the U.S., Canadian, c	or International Medical School. (If affili	ated)			
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NOTE: The completed form must be mailed directly from the facility to the Board to be acceptable.